CHAPTER 21:

Mental Health Issues

Juvenile Probation Officer and Caseworker Self-Instructional Manual

CHAPTER 21: MENTAL HEALTH ISSUES

INTRODUCTION

Mental health issues within the juvenile justice system have taken center stage over the past decade. Youth coming into the system are often diagnosed with mental health disorders and medicated accordingly.

Sometimes the medications are effective in modulating, mitigating and perhaps, remediation inappropriate behaviors in youth. Often, youth are over medicated, misdiagnosed, and in need of accurate assessment.

This chapter is design to familiarize the probation officer/caseworker with some of the most common mental health disorders. It is not meant to be an all-inclusive list of disorders or diagnostic material. The descriptors are brief but highlight the primary features of the disorder to assist the probation officer/caseworker in effectively working with the youth. In addition, some basic "intervention" strategies to be used when working with these cases, and community resources, are included. Publications and websites have been added as a resource.

Mental Health Disorders

Mental health disorders are described through a full-spectrum lens. They vastly range in characteristics and diagnosis. However, they can typically be classified in one of the following categories:

- Mood Disorders
- Attention Deficit and Disruptive Behavior, Personality Disorders
- Impulse-Control Disorders
- Reactive Attachment Disorder
- Anxiety Disorders
- Adjustment Disorders
- Learning Disorders
- Substance Abuse Disorders
- Psychotic Disorders
- Self-Mutilation

More detailed and diagnostic information is available in the Diagnostic and Statistical Manual of Mental Disorders (DSM IV). (For simple information in the DSM IV see: http://en.wikipedia.org/wiki/Diagnostic_and_Statistical_Manual_of_Mental_Disorders

MOOD DISORDERS

Depressive Disorders

A major depressive disorder: Typically characterized by one or more episodes lasting a period of at least two weeks and manifesting a depressed mood or the loss of interest or pleasure in nearly all activities. In children, the mood may be irritable rather than sad.

For a more accurate diagnosis, the individual must also experience at least four additional symptoms that include:

1. Significant change in appetite or weight,
2. Sleep and psychomotor activity;
3. Decreased energy; feelings of worthlessness or guilt; difficulty thinking, concentrating or making decisions; or
4. Recurrent thoughts of death or suicidal ideation, plans, or attempts.

MOOD DISORDERS

Depressive Disorders *(continued)*

Another factor includes the episodes are progressive in nature. Impairment in social, occupational, or other important areas of functioning are also a key diagnostic factor.

A minor depressive disorder: Similar to a major depressive disorder in duration but involves fewer symptoms and less impairment. Again, progressively worsening episodes must exist.

Dysthymic disorder: Characterized by at least two years of a pervasively depressed mood accompanied by additional depressive symptoms that do not meet criteria for a major depressive episode.

BIPOLAR DISORDERS

Bipolar I Disorder

Characterized by the occurrence of one or more manic episodes or mixed episodes and often, one or more major depressive episodes. In addition, the episodes cannot be accounted for by a diagnosis of schizophrenia or other psychotic conditions. Completed suicide occurs in 10 – 15 percent of these diagnosed individuals and abusive, violent behavior may occur during manic episodes or during those with psychotic features. Other associated problems may include truancy, academic failure, occupational failure, episodic antisocial behavior or relational difficulties. Approximately 10 – 15 percent of adolescents with recurrent major depressive episodes will go on to develop Bipolar I Disorder.

Bipolar II Disorder

Characterized by one or more major depressive episodes, accompanied by at least one hypomanic episode.

Major Depressive Episode Diagnosis Criteria

Five or more symptoms present from following list:

- Depressed mood most of the day nearly every day;
- Diminished interest in most activities nearly every day;
- Significant weight loss or gain or change in appetite;
- Insomnia or hypersomnia nearly every day;
- Fatigue or loss of energy nearly every day;
- Feelings of worthlessness or excessive guilt nearly every day;
- Diminished ability to think or concentrate nearly every day;
- Recurrent thoughts of death; or
- Psychomotor agitation or retardation nearly every day.

Manic Episode

Distinct period of abnormally and persistently elevated, expansive, or irritable mood lasting at least one week.

Mood disturbance is severe causing impairment in job, social, and relationship activities.

Three or more of the following symptoms during the mood period:

- Inflated self esteem;
- Decreased need for sleep;
- More talkative than usual;
- Thoughts are racing;
- Distractibility;
- Increase in goal directed activity; and
- Excessive involvement in activities with potentially painful consequences.

Hypomanic Episode

Have the identical list of characteristic symptoms of manic episode.

Disturbance is not sufficiently severe to cause marked impairment in social or occupational functioning.

Attention-Deficit and Disruptive Behavior Personality Disorders

Attention-Deficit/Hyperactivity Disorder (ADHD)

- Characterized by prominent and persistent patterns of inattention and hyperactivity impulsivity;
- Predominately hyperactive-impulsive type;
- Some impairment in at least two areas of functioning must occur; and
- Often do not follow through on requests, work is messy and incomplete, and there must be clear evidence of interference with developmentally appropriate social, academic, or occupational functioning.

Conduct Disorder

Characterized by a repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated.

Behaviors fall into four main groups:

1. Aggressive conduct that threatens or causes physical harm to people or animals;

2. Nonaggressive conduct that causes property loss or damage;

3. Serious violations of rules; and

4. Being deceitful or theft.

At least three behaviors listed above must have been present over the past 12 months. Behaviors are often present in a variety of environs including home, school and/or the community. Minimization of behaviors is prevalent. Children often initiate aggressive behaviors.

Oppositional Defiant Disorder

Characterized by a recurrent pattern of negative, defiant, disobedient and hostile behavior toward authority figures, that persists for more than six months.

Typically reflects frequent occurrence of at least four of the following behaviors:

1. Losing temper;
2. Arguing with adults;
3. Actively defying or refusing to comply with requests or rules; or
4. Deliberately doing things that annoy others, easily annoyed by others, blames others for own mistakes or misbehavior, angry and resentful, and vindictive compared to peers.

May also include deliberate testing of limits, persistent stubbornness, resistance to directions and failing to accept blame. Most often manifested in home and may not be evident at school or within community.

Antisocial Personality Disorder

Essential feature is a pervasive pattern of disregard for, and violation of, the rights of others that begins in childhood or early adolescence and continues into adulthood.

- Must be 18 years old or older with a history of symptoms of Conduct Disorder prior to age 15 in order to be accurately diagnosed.
- May include a pattern of impulsivity, recklessness, extreme irresponsibility and/or aggressive behaviors.

Borderline Personality Disorder

Features include a pervasive pattern of instability of interpersonal relationships, self-image and affects with marked impulsivity that begins in early adulthood and is present in a variety of contexts.

- Make frantic efforts to avoid real or imagined abandonment.
- Perception of impending separation or rejection or loss of external structure can lead to profound changes in self-image, affect, cognition and behavior.
- Very sensitive to environmental circumstances.
- Intense abandonment fears and inappropriate anger when faced with realistic time-limited separation.
- Pattern of unstable and intense relationships, idealize potential caregivers/lovers quickly, demand to spend a lot of time together and share intimate details early in relationships.
- Display impulsivity in potentially self-damaging areas of behavior.
- May display marked reactivity to moods.

IMPULSE-CONTROL DISORDERS

Intermittent Explosive Disorder

Characterized by the occurrence of discrete episodes of failure to resist aggressive impulses that result in serious, assaultive acts or destruction of property.

Degree of aggressiveness expressed during an episode is grossly out of proportion to any provocation or precipitating psycho social stressor.

Reactive Attachment Disorder

Markedly disturbed and developmentally inappropriate social relatedness in most contexts that begins before age five years and is associated with grossly pathological care that does not take into account the child's needs for comfort, stimulation, and affection.

Two types: Inhibited and Disinhibited

Inhibited: Child persistently fails to initiate and respond to most social interactions in a developmentally appropriate way; shows a pattern of excessively inhibited, hyper-vigilant, or highly ambivalent responses.

Disinhibited: A pattern of diffuse attachments; exhibits indiscriminate sociability or lack of selectivity in the choice of attachment figures.

ANXIETY DISORDERS

Social Phobia

Characterized by significant anxiety, provoked by exposure to types of social and performance situations.

Post Traumatic Stress Disorder (PTSD)

Development of characteristic symptoms following exposure to an extreme traumatic stressor, involving direct personal experience of an event that involves actual or threatened death, serious injury, threat to one's physical integrity, or witnessing of such.

Characteristic symptoms include re-experiencing an extremely traumatic event accompanied by symptoms of increased arousal and by avoidance of stimuli associated with the trauma.

Symptoms cause significant impairment or distress in social, occupational, or other important areas of functioning.

Re-experiences may include recurrent and intrusive memories of the even or recurrent, distressing dreams during which the event is replayed.

In rare instances, dissociative states lasting from a few seconds to several hours may occur.

Panic Attacks

Periods of intense fear or discomfort with four or more symptoms developing abruptly and peak within ten minutes:

- Palpitations, pounding heart,
- Sweating,
- Trembling or shaking,
- Sensations of shortness of breath or smothering,
- Feeling of choking,
- Chest pain or discomfort,
- Nausea or abdominal distress,
- Feeling dizzy, unsteady, lightheaded, faint,
- Feelings of unreality or being detached from oneself,
- Fear of losing control or going crazy,
- Fear of dying,
- Numbness or tingling sensations,
- Chills or hot flashes.

Adjustment Disorders

The development of clinically significant emotional or behavioral symptoms in response to an identifiable psycho-social stressor or stressors. The symptoms must develop within three months after the onset of the stressor. This can be characterized by the following: depressed mood, with anxiety, disturbance of conduct, or mixed emotion and conduct.

LEARNING DISORDERS

Learning Disability

A disorder in the basic psychological processes involved in understanding or using language, which may manifest itself in an imperfect ability to listen, think, speak, read, write, spell, or do math.

The term includes such conditions as perceptual handicaps, brain injury, minimal brain dysfunction, dyslexia, and developmental aphasia.

Determination is based on a comprehensive evaluation by a multidisciplinary team.

Areas of Discrepancy:

- Oral expression,
- Listening comprehension,
- Written expression,
- Basic reading skills,
- Reading comprehension,
- Mathematics calculations,
- Mathematics reasoning.

Emotionally Impaired

Determined through manifestation of behavioral problems, primarily in the affective domain, over an extended period of time, which adversely affect the person's education to the extent that the person cannot profit from regular learning experiences without special education support.

Characteristics:

- Inability to build or maintain satisfactory interpersonal relationships within the school environment;
- Inappropriate types of behavior or feelings under normal circumstances;
- General pervasive mood of unhappiness or depression;
- Tendency to develop physical symptoms or fears associated with personal or school problems; and
- Does not include socially maladjusted unless it is determined the person is emotionally impaired.

Mental Retardation/Educable Mentally Impaired

Characterized by significantly subaverage, general intellectual functioning that is accompanied by significant limitations in adaptive functioning in a least two of the following areas: communication, self care, home living, social/interpersonal skills, use of the community resources, self direction, functional academic skills, work leisure, health, and safety. Onset must occur before 18 years of age.

Asperger's Disorder

Features are severe and sustained impairment in social interaction and the development of restricted, repetitive patterns of behavior, interests, and activities.

Substance Abuse Disorders

Essential feature is a cluster of cognitive, behavioral and physiological symptoms that indicate continued use of substances despite significant substance-related problems.

Pattern of repeated self-administration, resulting in tolerance, withdrawal and compulsive drug-taking behavior.

- "With physiological dependence" diagnosis involves the evidence of tolerance and withdrawal;
- "Without physiological dependence" diagnosis involves no evidence of withdrawal or tolerance, but is characterized by a pattern of compulsive use;
- Diagnostic criteria includes: a maladaptive pattern of use leading to clinical impairment or distress as manifested by one or more of the following within a 12 month period of time:

  a). Recurrent substance use resulting in failure to fulfill obligations at work, school or home;

  b). Recurrent use in situations in which it is physically hazardous, e.g. driving an automobile, operating machinery, etc.;

  c). Recurrent substance-related legal problems; and

  d). Continued use despite persistent relationship or interpersonal problems.

PSYCHOTIC DISORDERS

Schizophrenia

- A psychotic disorder that can be simply characterized by disorganized thought patterns;
- Essential features are a mixture of characteristic signs and symptoms (both positive and negative) that have been present for a significant portion of time during a one month period with some signs of the disorder persisting for at least six months;
- Positive symptoms may appear to reflect an excess or distortion of normal functions;
- Negative symptoms appear to reflect a diminution or loss of normal functions. They may include distortions or exaggerations of inferential thinking (delusions), perception (hallucinations), language and communication (disorganized speech);
- Behavioral (grossly disorganized or catatonic behavior); and
- Signs and symptoms are marked with social or occupational dysfunction.

Refer to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM IV) for Additional Information and Subtypes.

Self-Mutilation

- Characterized by the injury resulting in injury to skin or body tissues that is a form of self-soothing;
- May be in the form of tearing, bruising, cutting, or burning of the skin;
- Provides relief and gratification from increasingly intense stress and/or anxiety;
- Is NOT suicidal behavior;
- MAY result in ACCIDENTAL suicide as a result of methods used to self-injure while seeking relief;
- May use tools or instruments, e.g. cigarette, erasers, iron, etc. for burning, swallowing sharp objects such as razor blades, excessive body piercing and tattooing, needles, swallowing toxic chemicals that burn, etc.

Trichotillomania

- Essential feature includes recurrent pulling out of one's own hair which results in visible hair loss.
- An increased sense of tension immediately before pulling out the hair or when attempting to resist the behavior may exist.
- May experience a sense of stress relief, pleasure, or gratification from behavior.

Intervention Strategies

Working with youth who have mental health issues can be challenging. The following list of intervention strategies represents suggested approaches that can insure better success when working with this population:

- Be patient!
- See them as a person first, not a diagnosis.
- Put yourself in their shoes.
- Get informed about the youth, family, and environs in which they live.
- Treat them with respect and affirmation.
- Be consistent, nurturing yet firm.
- Be gender-responsive; get trained so you can respond appropriately.

INTERVENTION STRATEGIES *(continued)*

- Be gender-responsive; get trained so you can respond appropriately.
- Be concrete, repeat instructions and important statements.
- Develop and use behavioral contracts.
- Ask them repeat and summarize what you have told them.
- If giving written material, have them read some out loud.
- Use games, art, or outside activities to help them talk more easily.
- If young male, ask to express emotions and feelings by drawing a picture about the "story" first and then describing it to you.
- Clarify jargon, abbreviations or other words they may not understand.
- Make appropriate referrals.

Stages of Progressive Change

- Preawareness that something isn't right.
- Awareness of that which is specifically not right.
- Working toward an identified goal through conscious behavior changes.
- Maintaining the behavior.

Types of Interventions

Relational – Builds trust based on consistency in developing the relationship.

Behavioral – Focuses solely on behaviors rather than emotional, mental health imperatives, i.e. monitoring substance abuse behaviors by drug testing, etc.

Cognitive-Behavioral – Focuses on thought processes and thinking errors; not recommended for females unless within a strong, relational context.

Mentoring – Appropriate, trained, adult mentors form relationships with youth to provide guidance and supportive role models for youth; some research indicates consistent mentoring programs, especially with females, may impact the neurotransmitters in the brain and repair attachment disorders.

Support Groups – Groups of youth who are facilitated and structured to provide peer support on general or specific topic issues causing difficulty in youth's life.

Types of Interventions *(continued)*

Psycho-Educational Groups – Supportive, educational and facilitated/structured groups that address specific needs of youth, i.e. retail fraud/decision-making group.

Female-Specific, Psycho-Educational Groups – Supportive, educational, time-limited, process/activity-based and facilitated/structured groups that address one or all of the six developmental domains (intellectual, emotional, relational/familial, spiritual, sexual, and physical) utilizing female-specific principles as identified by the National Institute on Crime. (See below for specifics).

Information and Referral – Specific need-driven information and referral services within the community to assist in addressing an identified need.

Contracts – May be behavioral, "no self-harming for self-mutilators", etc. Contracts are used to obtain compliance in preventing further inappropriate or life-threatening behaviors.

Female Responsive Services Principles

The National Institute of Corrections (NIC) has researched the needs for girls within the justice system and has identified essential areas, which need to be addressed in order to adequately treat girls.

Female-Responsive Programming

The following is a synopsis of NIC's value statement regarding female-responsive programming:

- Services for females are designed to be inclusive of race, ethnicity, class, sexual orientation, and individual life experience simultaneously.
- Services for females are designed to be relational and seek to support the development of healthy relationships.
- Services for females are designed to be restorative in that girls need to not only make amends to those they have harmed but also, need to address the root cause of their behavior, which may be grounded in their own victimization.
- Services that seek to restore relationships.
- Services for females are designed to assist girls in paying attention to societal influences through teaching them critical thought.
- Services for females are designed to be multileveled reflecting their place in the community, nationally, and on a global basis.
- Services must also be holistic and sustainable over time.

Educational/Schools

Local schools have a wealth of resources that assist students with mental health issues. Some of the key personnel involved in this are as follows:

Classroom Teacher – May refer child for special education testing or make recommendations to parents and school for special mental health assistance.

Special Education Teacher – Teaches children who qualify for special education but also, may refer child for additional, supportive treatment resources.

School Psychologist – Typically, tests children for special education determination and assessment.

Counselor/Social worker – Provides oversight and some limited counseling services to special education certified student, parent(s) and consultation with teacher(s).

Special Education Director – Provides oversight to special education programs within the school and monitors compliance with special education law.

Educational/Schools *(continued)*

Assistant Principal/Principal/Administration – May refer student for special education testing based on observed behaviors and need; may assist in the provision of structure for student and relational issues.

Local Intermediate School District (ISD) offices also play a vital role in addressing mental health issues within the student population through offering special education programming and staff. The ISD offers specialized schooling for handicapped or developmentally challenged children in addition to a variety of special education trainings. Social workers, interventionists, and special education staff are available in most ISD locations.

Universities offer a variety of resources as well through research, libraries, student manpower, educational staff, etc. For more information, see Chapter 15 on Individualized Education Programs.

Courts

Many family divisions of the circuit courts offer treatment programs to remediate antisocial behaviors and gain behavior remediation through court ordered services.

Agencies

Several nonprofit agencies offer mental health services within local communities. The following is a brief list of national-level, nonprofit agencies that might be helpful. Check your local telephone book for additional resources.

Publications/Newsletters

The following are some publications that offer mental health information for reference purposes. There are too many types of these publications to list and thus, this list reflects some resources that are not typical but offer a variety of helpful information.

- Civic Research Institute, Inc., 4478 Route 27, P.O. Box 585, Kingston, N.J. 08528, 609.683.4450
- Women, Girls and Criminal Justice
  Prevention Researcher
  Emotional & Behavioral Disorders in Youth
- American Psychiatric Association, 1400 K Street, N.W., Washington, DC 20005
  Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)
- Dads and Daughters, 34 E. Superior Street, Ste. 200, Duluth, MN 55802
  Daughters Newsletter

Websites

- The National Center on Education, Disability, and Juvenile Justice, University of Maryland: http://www.edjj.org
- National Institute of Mental Health: http://www.nimh.nih.gov/index.shtml